Overview of Money Follows the Person Demonstration Project

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Project Director

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Today's Presentation

- Part I: MFP 101
  - What MFP is
  - Who it Serves in NC
  - How the transition process works
  - How to make an MFP application

- Part II: Where we are going over next few years

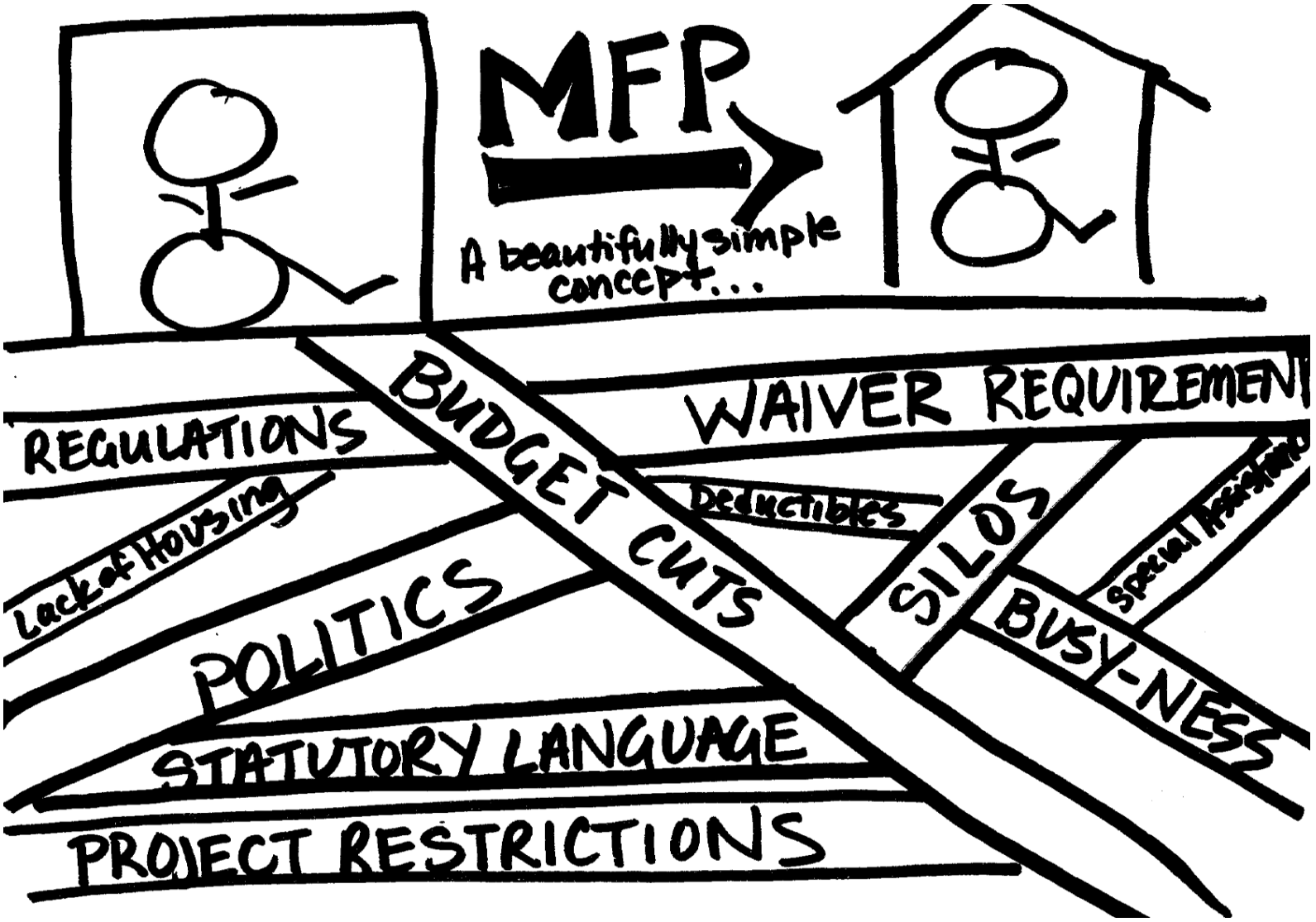
Why Do Transitions Matter?

The Human Reasons

What is MFP?

A beautifully simple concept….

An opportunity to support people to transition into their homes and communities.


MFP
A beautifully simple concept...
REGULATIONS
BUDGET CUTS
WAIVER REQUIREMENT
Lack of Housing
Deductibles
SILOS
Special Populations
POLITICS
BUSY-NESS
STATUTORY LANGUAGE
PROJECT RESTRICTIONS

NC MFP: A Quick Refresher on our History

- A Public Initiative and a Community Effort
  - Grass-roots advocacy + Medicaid management
- 2005: Federal MFP legislation
- 2006: NC application to have MFP Demonstration Project
- 2009: Transition services begin
- 2010: Federal MFP legislation extended
- 2018: NC MFP ends transition activities, but transitions will continue!

So, what's going to happen afterwards?

To date, NC MFP has supported nearly 900 transitions!

MFP: 2 Primary Purposes

1. Support the transition process
2. Promote systems change:
   - Increase Home and Community Based Services
   - Eliminate Barriers
   - Continued Provision of Services
   - Quality Improvement

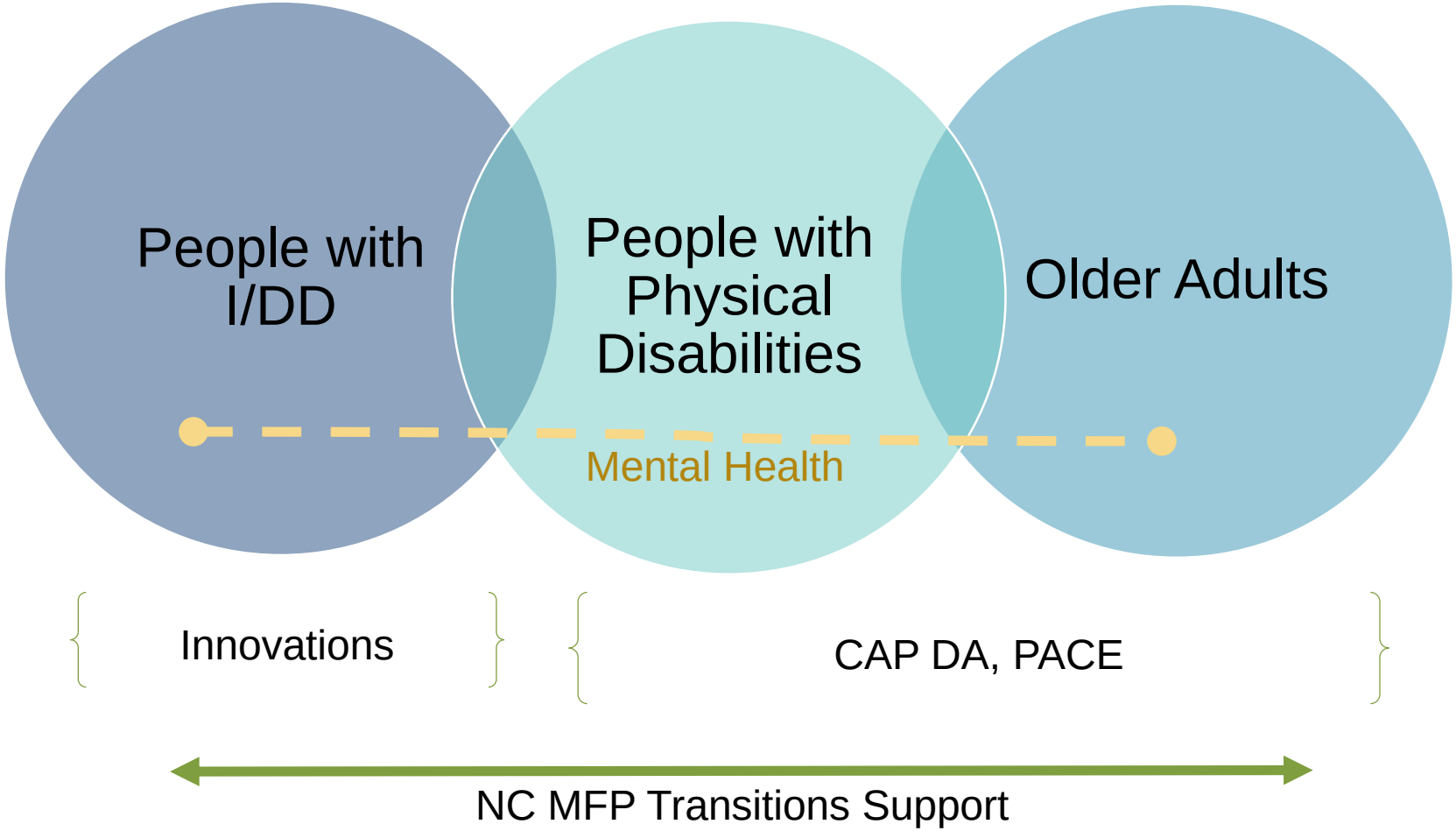
If we only support people to transition,
we're only doing half our job.

"So…..exactly who does MFP serve and what do you do?"

"The MFP Demonstration Project will transition qualified individuals from qualified inpatient facilities to qualified residences in the community."

What does this mean????

Qualified Individuals: NC MFP Focuses on 3 Primary Populations



Qualified Inpatient Facilities

Medicaid Eligible Residents(*) in:

- Nursing Facilities
- ICFs-IID
- State Developmental Centers
- PRTFs if also qualifies for Innovations
- State Psych hospitals in extremely limited situations.

- NOT adult care homes

(*) Resident must have been in facility setting (or combination of) for three continuous months prior to transition.

Medicare Part A Rehab considerations

Timeframe may include time in acute care settings.

NC MFP Eligibility on one Page

Who can apply for NC MFP?

- Medicaid eligible residents of:
  - Nursing Facilities
  - ICFs-IDD
  - State Developmental Centers
  - PRTFs if also qualifies for Innovations
  - State Psych hospitals in extremely limited situations.
  - NOT adult care homes
- Resident must have been in facility setting (or combination of) for three months prior to transition.
- Medicare Part A Rehab considerations
- Timeframe may include time in acute care settings.
- Three months must be continuous.

Who can transition under NC MFP

- MFP participants who meet the criteria for:
  - Innovations waiver
  - CAP DA
  - PACE

Qualified Residences:

- A home owned or leased by the individual or the individual's family member,
- An apartment with an individual lease, with lockable access and egress, and includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control, and
- A residence in a community-based setting in which no more than four unrelated individuals reside (*).

(*) For individuals with intellectual/developmental disabilities in NC only

NC MFP's Benefit to the Individual

- CAP/Innovations slot or PACE participation
- Project pays for first year, becomes regular waiver slot afterwards.
- NO change to waiver services---just more support through MFP for the transition time.
- Start up funding to assist in transitions
- Broadly construed: furniture, ramps, services (like therapeutic consultation, staff training, etc.)
- Additional case management
- Transition coordination support
- Priority access to housing subsidies

(*) For individuals with intellectual/developmental disabilities in NC only

The MFP Transition Process

- Every transition is unique, facing different issues and different circumstances.
- Transitions can take a few weeks to several months.
- Not everyone will need MFP to transition.
- Not everyone transitions.
- Transitions are collaborative between MFP transition coordinators, participants, supports and facilities.
- Person guides process.

Who Coordinates the Transition?

MFP Beneficiaries with I/DD

- LME/MCOs coordinate transition planning; Innovations waiver enrollment and MFP Innovation waiver slot allocations.
- Each MCO has transition coordinators specifically trained to support MFP participants.

Beneficiaries with Physical Disabilities or Aging

- MFP partners with different transition coordinator contractors in each region.
- MFP has long-standing partnership with DVR-IL
- CAP DA case managers or PACE staffers work in partnership with MFP transition coordinators and are responsible for enrollment into specific CAP DA or PACE program.

Occasionally, MFP will receive an application from someone who is in a nursing facility but is also eligible for IDD services. NC MFP will work to ensure all transition partners are brought together.

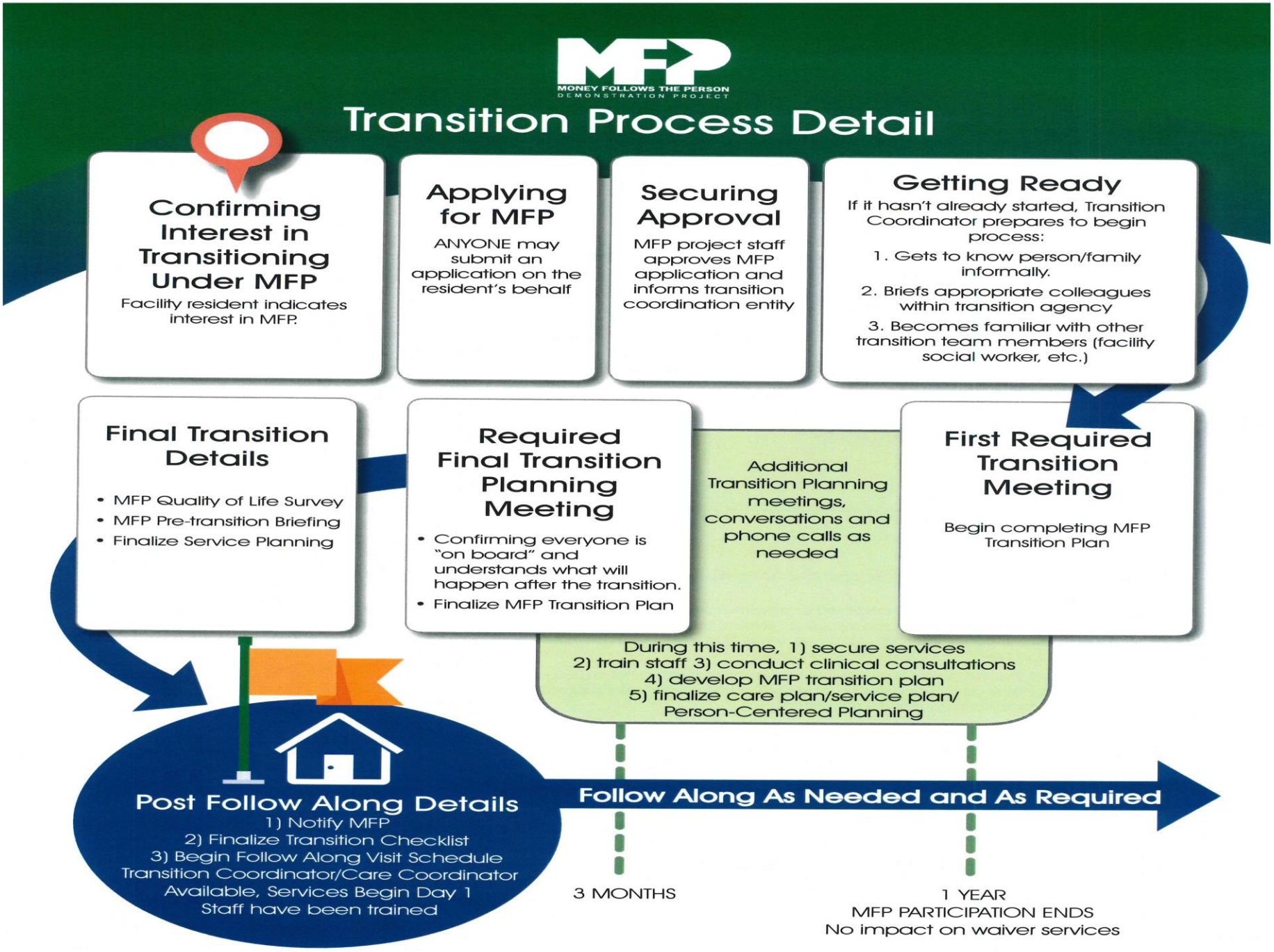
How to Apply for an MFP Slot

NC MFP Application Information

- Anyone can submit a referral.
- Application forms available at: https://dma.ncdhhs.gov/providers/program-services/money-follows-the-person-MFP
- Referral takes about a week to process.
- Approval for MFP does not guarantee approval for waiver or PACE program.

What Happens Next?

- Application Reviewed by MFP staff
  - If questions or concerns, will follow up with submitting entity; otherwise application will be approved.
- Linkage email sent to all anticipated partners who have an email address:
  - Transition Coordinator, waiver team, facility, others
  - Challenge: communicating approval to resident.
- Transition coordinator will reach out to resident/family/social worker to introduce self and gather some primary information.
- Transition planning meetings, integrating housing search and solidifying natural support.


MFP
MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT
Transition Process Detail
Confirming Interest in Transitioning Under MFP
Facility resident indicates interest in MFP.
Applying for MFP
ANYONE may submit an application on the resident's behalf
Securing Approval
MFP project staff approves MFP application and informs transition coordination entity
Getting Ready
If it hasn't already started, Transition Coordinator prepares to begin process:
1. Gets to know person/family informally.
2. Briefs appropriate colleagues within transition agency
3. Becomes familiar with other transition team members (facility social worker, etc.)
First Required Transition Meeting
Begin completing MFP Transition Plan
Additional Transition Planning meetings, conversations and phone calls as needed
Required Final Transition Planning Meeting
• Confirming everyone is "on board" and understands what will happen after the transition.
• Finalize MFP Transition Plan
Final Transition Details
• MFP Quality of Life Survey
• MFP Pre-transition Briefing
• Finalize Service Planning
During this time, 1) secure services
2) train staff 3) conduct clinical consultations
4) develop MFP transition plan
5) finalize care plan/service plan/
Person-Centered Planning
Post Follow Along Details
1) Notify MFP
2) Finalize Transition Checklist
3) Begin Follow Along Visit Schedule
Transition Coordinator/Care Coordinator Available, Services Begin Day 1
Staff have been trained
Follow Along As Needed and As Required
3 MONTHS
1 YEAR
MFP PARTICIPATION ENDS
No impact on waiver services

Here is what we know that works

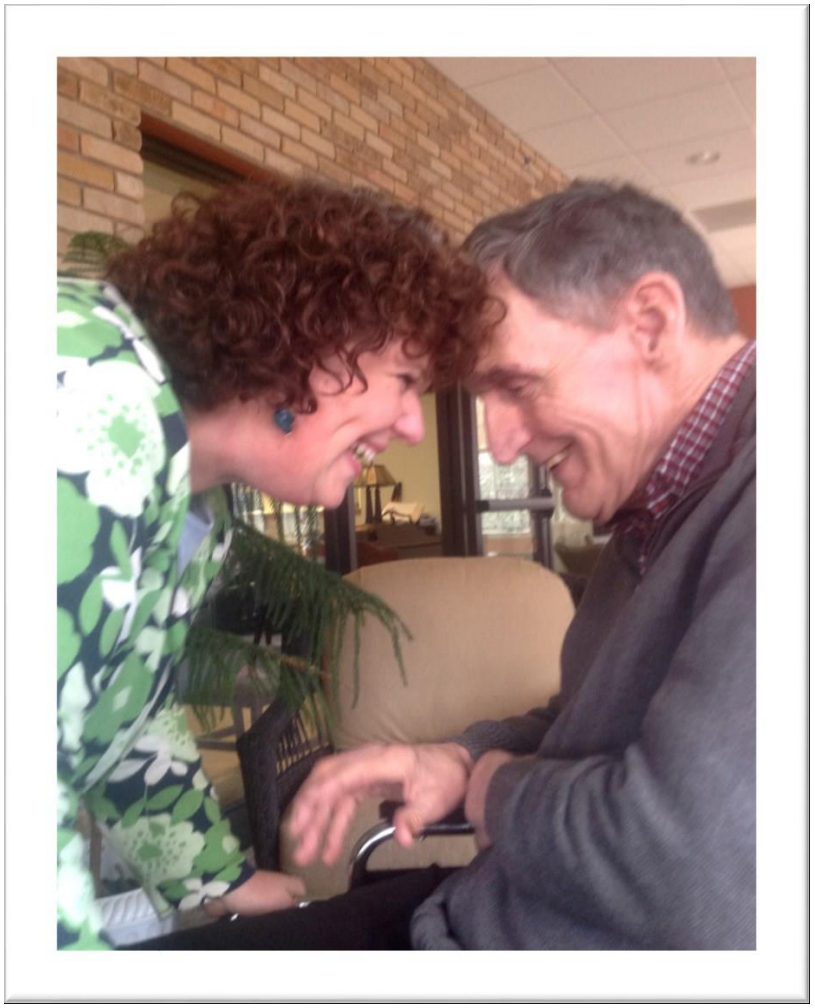
- Participants/their families or guardians are central in the planning.
- Services identified, available and staff trained prior to transition.
- A clear “good fit” between staff/Alternative Family Living (AFL) arrangement and person.
- Strong, clear, ample communication between transition team members.
- Making sure key details are clearly identified and addressed prior to transition.
- Ensure behavioral supports
- Effective follow along—troubleshoot early.
- Services/supports must remain coordinated and cohesive after the transition.

Success Story: Meet Alyssa

Alyssa 2nd from the left and her family.

Transitioned under the Innovations Waiver

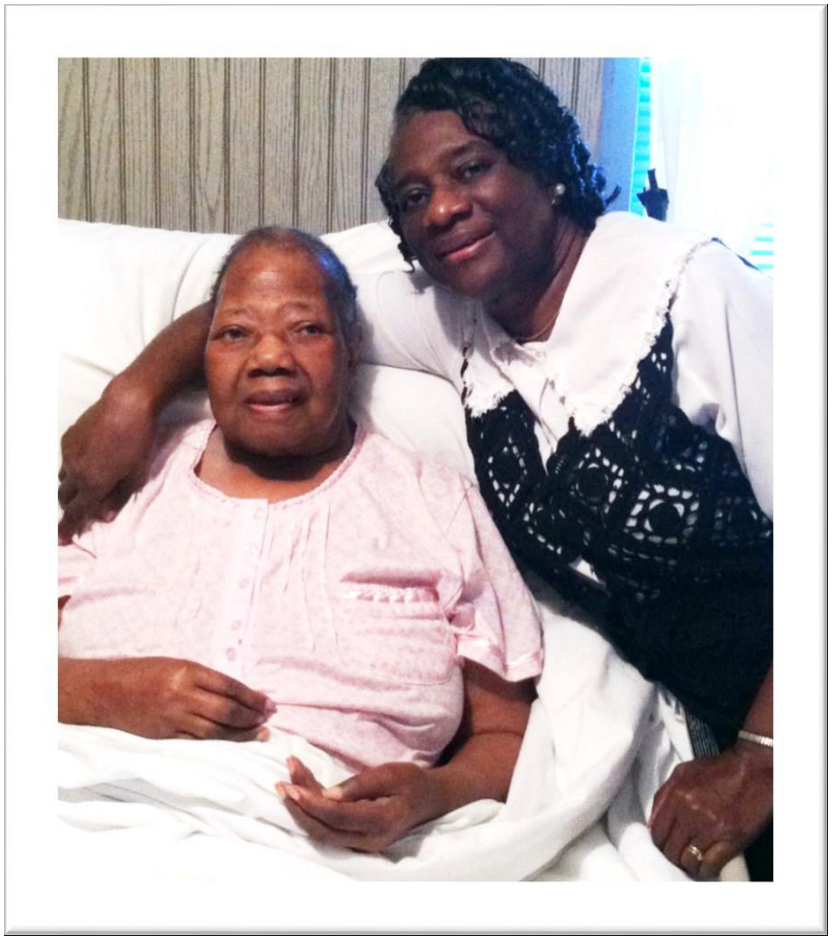
Success Story: Meet Sam



Transitioned under the Innovations Waiver

Megan and Sam

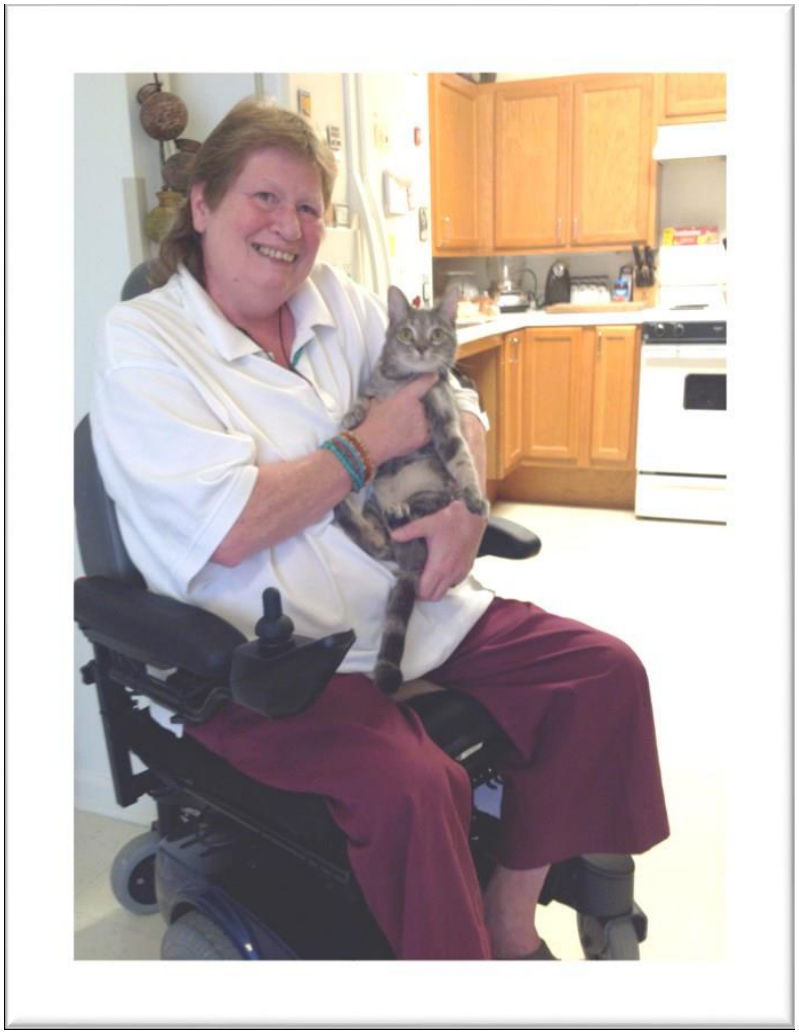
Success Story: Meet Etta



Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

Etta and her daughter Lulu

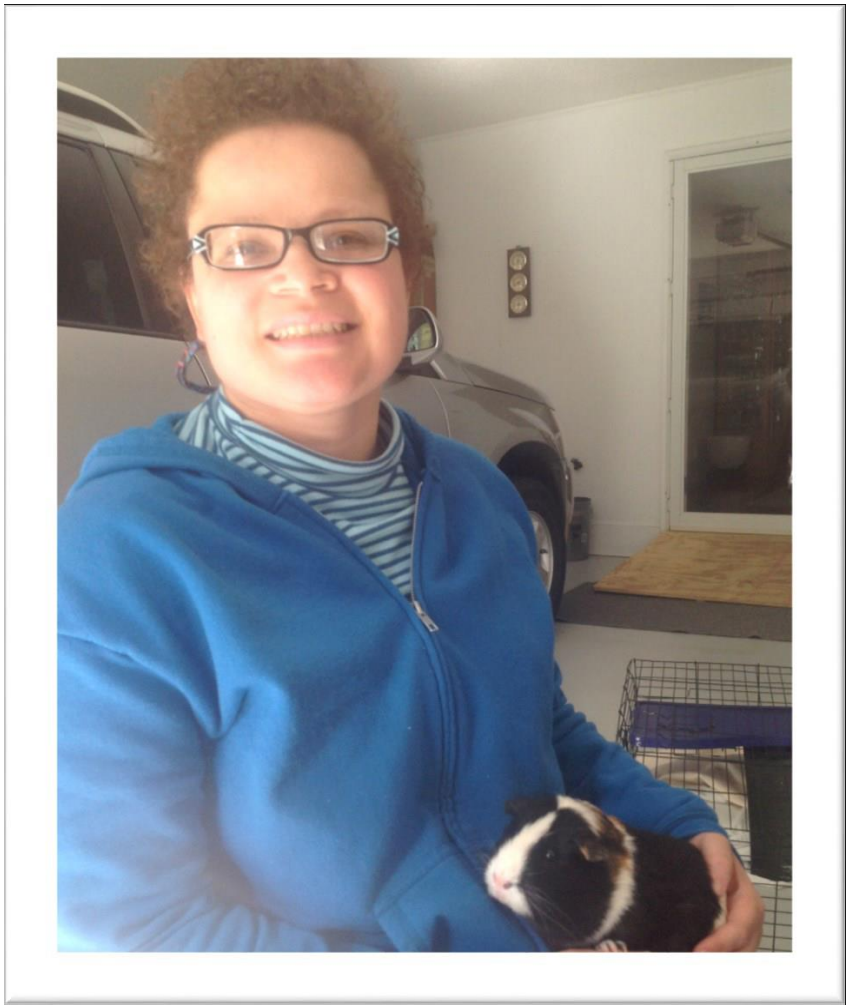
Success Story: Meet Jackie Lee



Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

Jackie Lee and her cat Tony

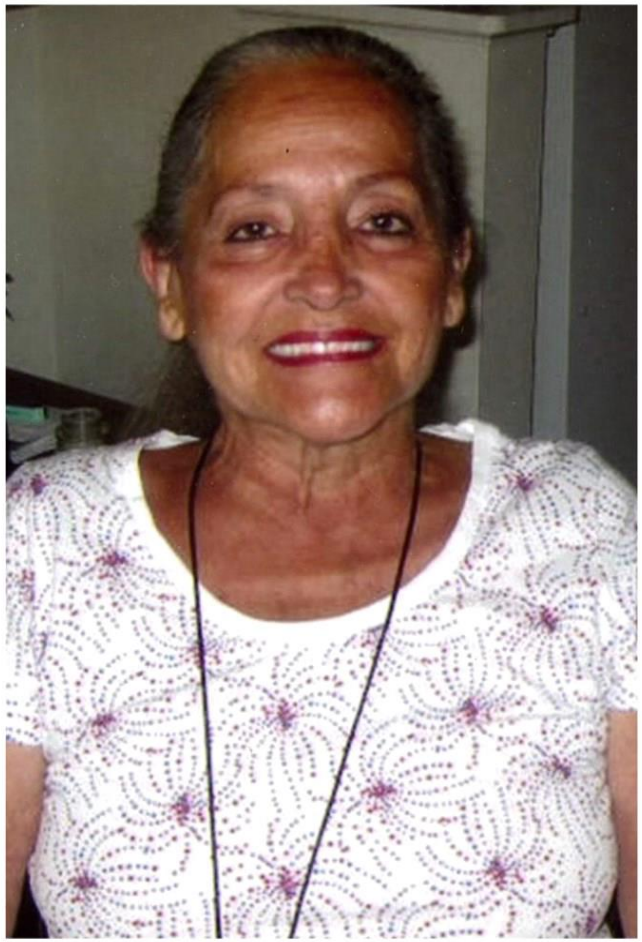
Success Story: Meet Mandy



Transitioned under the Innovations Waiver

Mandy and Pocahontas

Success Story: Meet Evelyn



Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

Success Story: Meet Alex

Transitioned under the Innovations Waiver

Success Story: Meet Nettie

Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

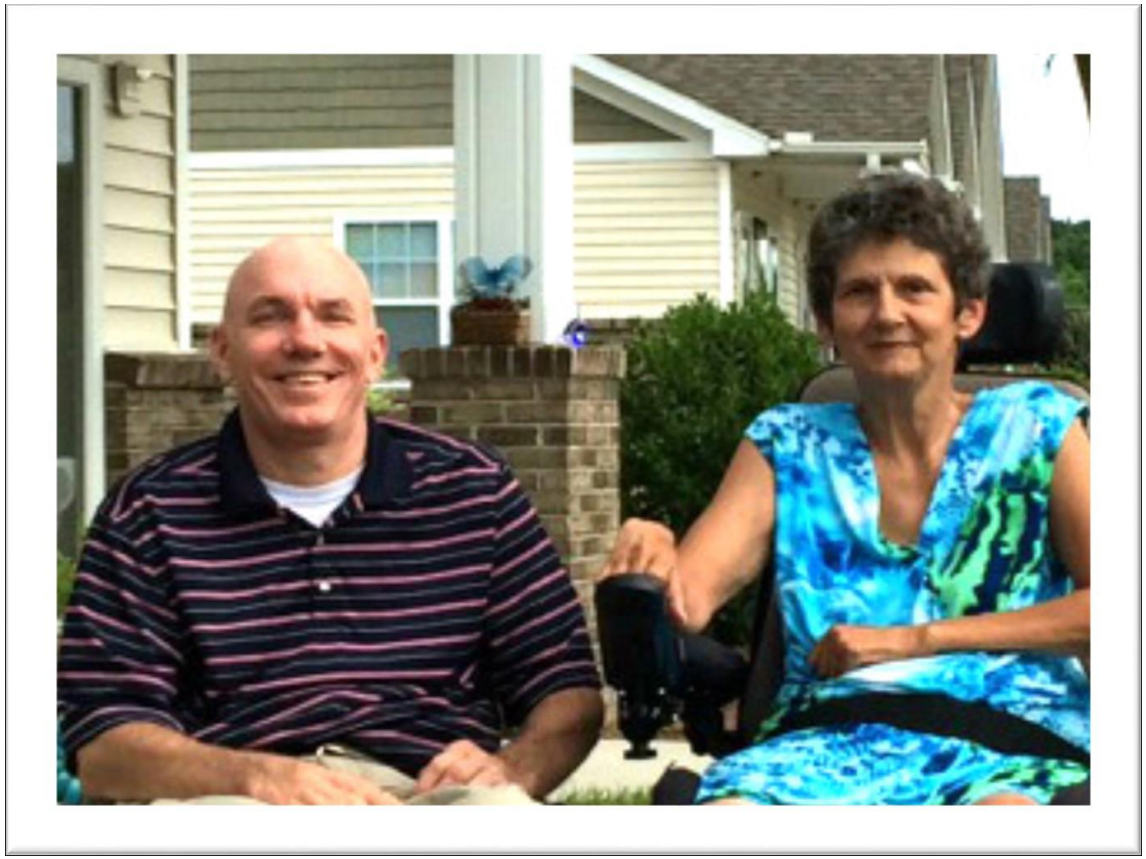
Nettie (front, center), Tara Williams, MFP Transition Coordinator (rear, left) and daughter, Nancy

Success Story: Meet Dylan

Jen Branham (MFP Transition Coordinator) and Dylan

Transitioned under the Innovations Waiver

Success Story: Meet Teresa



Teresa with Mark Steele, N.C. Division of Vocational Rehabilitation Services, Independent Living Program

Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

Success Story: Meet Sherwood

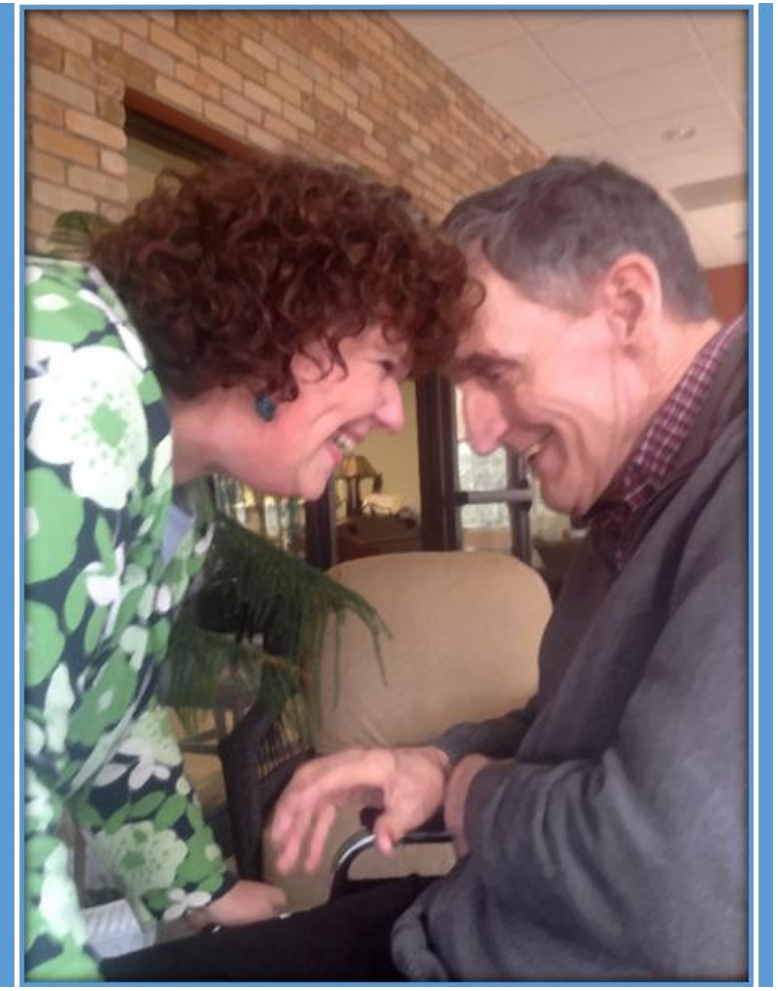
Transitioned under the Community Alternatives Program for Disabled Adults (CAP/DA) Waiver

Sherwood in his new home with Transition Coordinator Andi Reese

Success Story: Meet Oshin

Transitioned under the Innovations Waiver

So How Will Our Time Be Spent Over the Next Few Years?

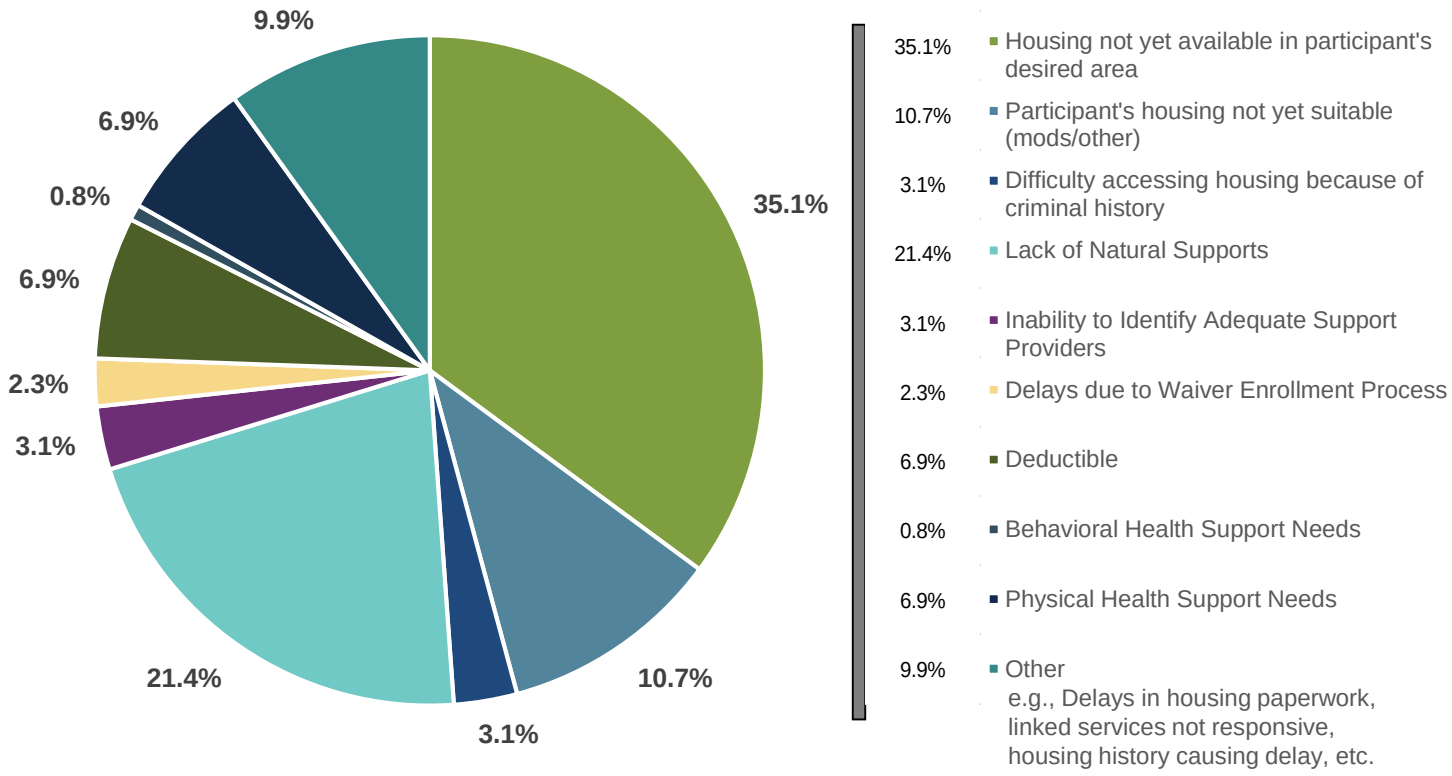


- Improving transition practices
- Helping shape a person-centered Long-Term Services and Support (LTSS) system
- Refining our NC MFP Sustainability Plan

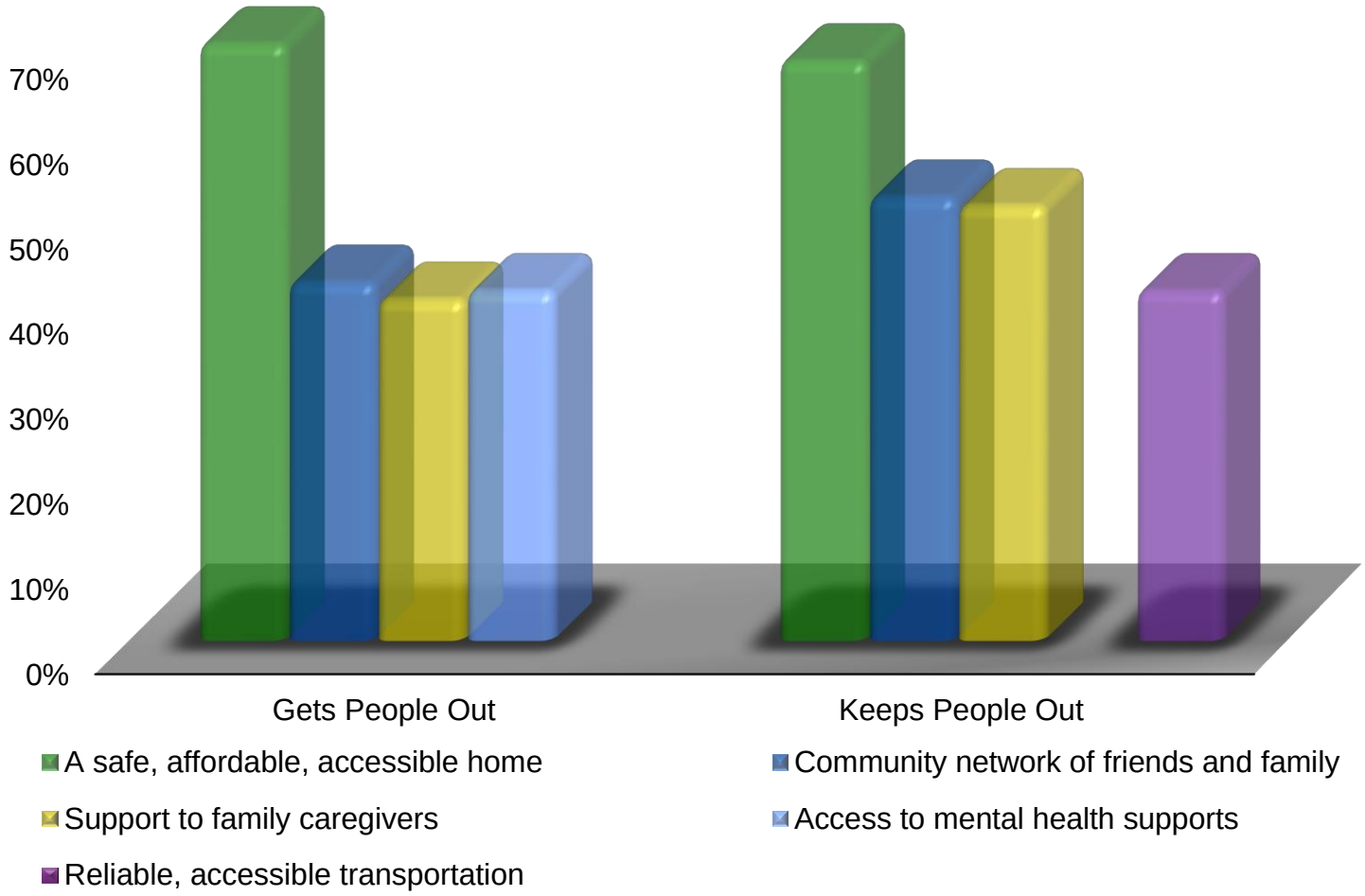
Promoting Systems Change

- Increase Home and Community-Based Services
- Eliminate Barriers
- Continued Provision of Services
- Quality Improvement

Reasons Given for Delays in Transitions Among Current MFP Participants



NC MFP Rebalancing Fund: Identified Stakeholder Priorities



SOURCE: MFP Rebalancing Fund Roundtable Survey (2014)

Initiatives that support promoting systems change

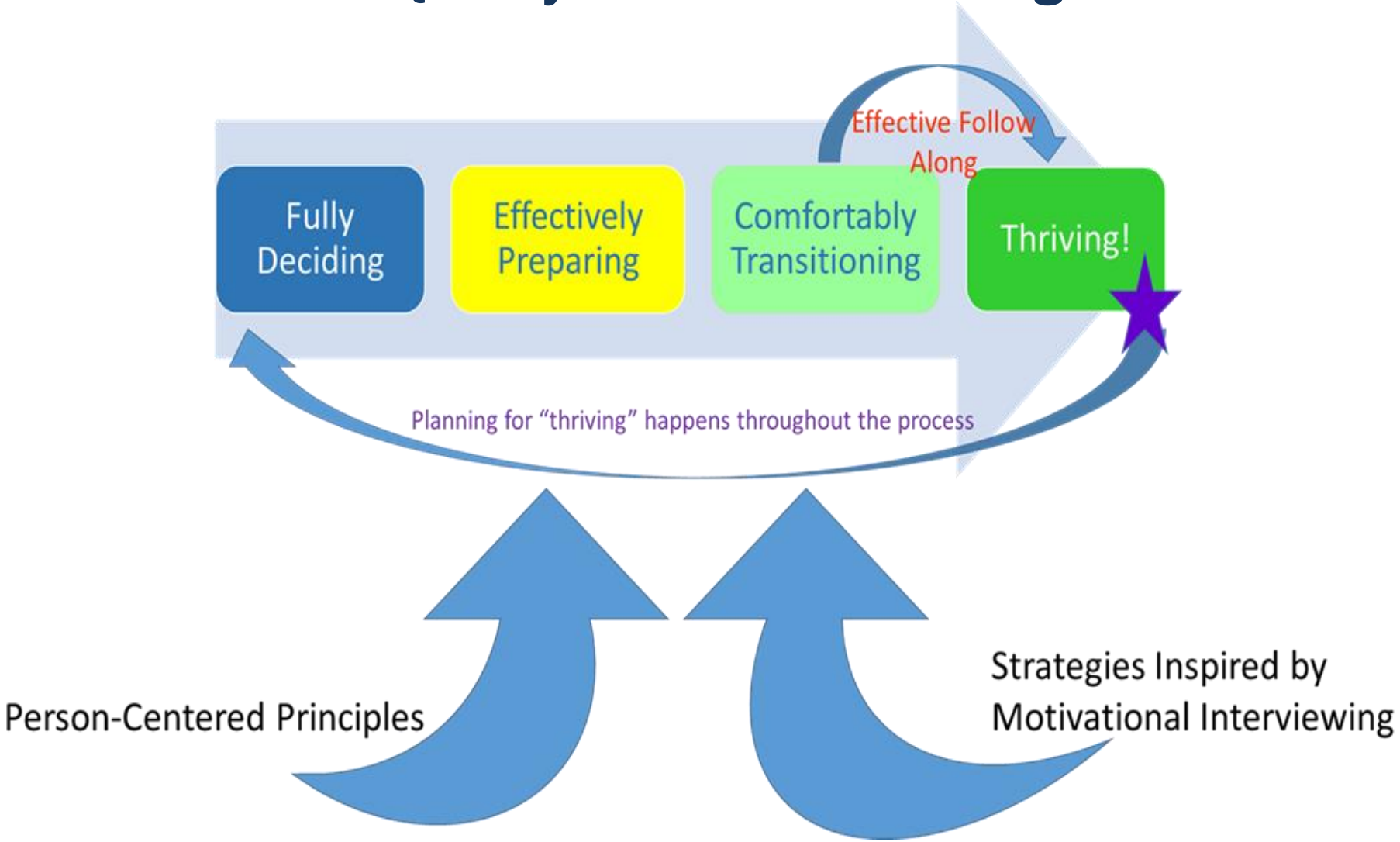
- North Carolina Community Transitions Institute
- Family Caregiver Support: Care Management Quality Initiative
- Supported Living: Making a Difference
- Transition Bridging Team
- CAP/DA Transition Coordination Partnership Project
- Transition Extension
- DMH Specialized Training Curriculum for MH/IDD
- Sustainability Analysis

North Carolina Community Transitions Institute

The purpose of this initiative is to establish consistent, department-wide, competency-based standards that ensure the consistent application of core transition concepts across long-term care communities.

- Summer-long professional development opportunity for transition professionals.
- Provides content immediately relevant to the practice of supporting a transitioning individual.
- Strengthens members' knowledge and use of person-centered practices and collaborative communication skills in transition specific contexts.
- Fosters professional collaboration.
- Generates recommendations for improvements to Department-sponsored transition activities.

Elements of Quality Transition Planning



Family Caregiver Support

The purpose of the initiative is to improve the quality of care management services and to focus on consistency in service delivery across the state, and help family caregivers continue to provide care in the community for their family members who are at risk of facility placement.

- Tests and evaluates new care planning/care management tools
- Develops assessments and care planning for both care recipients and care givers
- Examines the role of respite in caregivers' satisfaction and their intent to pursue facility-based placement for their family members

Supported Living: Making a Difference

The purpose of the initiative is to expand and strengthen NC's capacity to support people with intellectual and developmental disabilities to live in the community according to supported living principles.

- Phase 1: statewide learning opportunity provided by experts in the field to orient MCO's to supported living principles.
- Phase 2: 3-year learning community to support organizations and individuals in building:
  - Private home dynamics (ownership, rental)
  - Person-centered staffing strategies
  - Individualized budgeting
  - Person-centered strategies to mitigate against isolation and loneliness

Transition Bridging Team

The purpose of this initiative is to pilot a bridging team concept, managed by selected LME/MCO's, and implement and evaluate the efficacy of certain transition-related interventions that ultimately improve functions, processes, and expectations related to quality transition practices.

- Supports identified individuals who experience a dual diagnosis of I/DD and serious behavioral challenges.
- Provides intensive, hands-on, time-limited oversight, and technical assistance to community-based support networks.

CAP/DA Transition Coordination Partnership

The purpose of this initiative is to pilot transition concepts that are intended to expedite and streamline the transition of individuals from qualified long-term care facilities into their homes and communities with appropriate support.

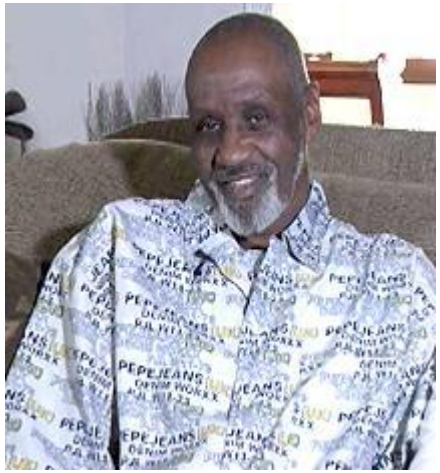
- Improving/impacting beneficiary service path trajectories through "upstream" interventions that anticipate interest in returning to home and community.
- Using Eden at Home person-centered planning model to increase the number of natural supports for transitioning individuals.

Why this matters….
Person-Centered Community living can be transformative

"This is a real home…"
-Mandy

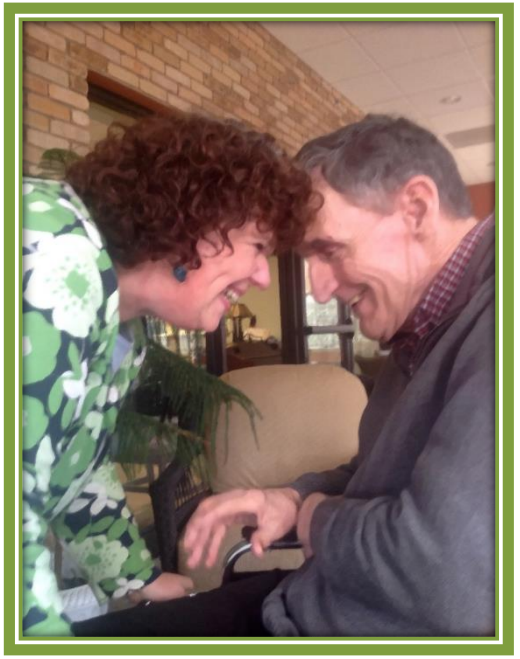
"Life is fabulous here."
-Jackie

"People have a great desire to have control over their day-to-day activities, to lead self-determined lives and to be included in their local communities."
-- Henry's DSS Social Worker



NC MFP Grant-Funded Transitions: Where We Are Now

- Last Congressional appropriation made in 2016, authorizing CMS and participating states to utilize federal grant funds through September, 2020.
- CMS requires that states complete MFP-grant sponsored transition activity by December, 2018, with follow along allowed through 2019.
- NC MFP began its sustainability planning in 2015. Plan can be found on our website. But the NC Medicaid landscape has changed!
- NC MFP funds a number of activities through grant funding:
  - Transition Coordination Network *
  - Start Up Funds and other Demonstration Services
  - State Staff Positions
  - LCA Network
- MFP also has STATE dollars (not federal grant dollars) known as Rebalancing Funds. These dollars accrue based on savings the state achieves through an enhanced federal match applied to services used by MFP participants.



The Ultimate Direction of NC MFP Activity

- The NC Medicaid program is shifting from a fee-for-service model to a managed care model.
- NC has submitted an application to do so to CMS, under 1115 Waiver authority.
- Over the next several years most (not all) Medicaid-funded services will be managed by prepaid health plans (PHPs).
- These PHPs are also responsible for coordinating the services and care of Medicaid beneficiaries.
- The timeline for implementation is staggered, with the folks MFP really focuses on (long-term nursing facility residents, CAP DA beneficiaries, and dually eligible beneficiaries) being integrated LAST.
- The timeline depends on several factors that aren't confirmed yet.
  - CMS has to approve the waiver, PHP procurement process, etc.

Approximate Timelines Related to NC Medicaid Managed Care

2019ish

PHPs go live, covering mostly moms and kids, but also other Medicaid beneficiaries who do NOT receive Medicare, including Medicaid-only PCS recipients and Medicaid-only short-term facility residents (under 90 days)

2021ish

Beneficiaries with significant behavioral health, I/DD, TBI support needs integrated (currently LME-MCO covered populations)

2023ish

Beneficiaries who receive CAP DA or CAP C and long-term nursing facility residents are integrated.

NOTE: Dually eligible beneficiaries are also delayed until 2023. PHPs will be required to offer Duals options that coordinate with Medicare program.

NOTE: **The "ish" matters:** All dates are estimates and contingent on other factors

Helping Shape the Interim Design: Objectives of the NC MFP Sustainability Analysis

To secure a clear description of NC's current transition activity landscape.

To clarify roles related to the transition functions and processes as reflected in applicable contracts, job descriptions and service definitions.

To receive recommendations for improving transition-related processes for target populations.

To receive recommendations for developing an interim approaches to transitions that ensures effective coordination of transitioning individuals.

To identify potential future LTSS population growth, with an emphasis on individuals under 65 with physical disabilities.

The Analysis Research Team Will Be Reaching Out To Our Partners

- MFP participants (current and former)
- MFP-supported Transition Coordinators
- Other transition coordination entities
- CAP DA Lead Agencies
- Local Contact Agencies
- State Staff
- Other stakeholders

Where to get more information

- Join our Roundtable stakeholders' group by emailing: mfpinfo@dhhs.nc.gov
- Visit our Website: https://dma.ncdhhs.gov/providers/program-services/money-follows-the-person-MFP
- Give us a (toll free) call! 1-855-761-9030
- Contact our wonderful local partners!